Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AQUATIC CARE PROGRAMS INC

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-13-3332-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to file a medical fee dispute resolution in which Risk Enterprise has erroneous denied our claims indicating 'partially/fully furnished by another provider. Per rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the healthcare or that provided direct supervision of an unlicensed individual who provided the healthcare. PTA was the rendering HCP.' Our [sic] August 21, 2012, this patient was treated by Linda Truong, physical therapist assistant whom was supervised by supervising physical therapist, Louise Wekob for the duration of 115 minutes…"

Amount in Dispute: $520.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs provided as part of the requestor's filing and/or attached hereto. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Laston.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2012	CPT Code 97113	$490.00	$413.13
August 21, 2012	CPT Code 97032	$30.00	$26.66

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the guidelines for medical bill submission by the health care

provider.

3. 28 Texas Administrative Code §134.600 sets out the guidelines for obtaining preauthorization
4. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement for professional services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment adjusted for absence of precert/preauth.
   - GP – Service delivered under OP PT care plan.
   - B20 – Srvc partially/fully furnished by another provider.
   - 193 – Original payment decision maintained.

Issues

1. Did the requestor obtain preauthorization for the services in dispute?
2. Did the requestor bill the services in dispute correctly?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance 28 Texas Administrative Code §134.600(p)(5), non-emrgency health care requiring preauthorization includes physical therapy services listed in the Healthcare Common Procedure Coding System. Review of the documentation submitted by the requestor finds that preauthorization was requested and approved under preauthorization determination number 711136616-01 for 3 sessions (1 x week x 3 weeks). Therefore the insurance carrier's denial of "197 – Payment adjusted for absence of precert/preauth" is not supported.
2. In accordance with 28 Texas Administrative Code §133.20(d)(2), the health care provider that provided the care shall submit its own bill, unless: the health care was provided by an unlicensed individual under the direct supervision of a licenced health care provider, in which case the supervising health care provider shall submit the bill. Review of the documentation submitted by the requestor finds that the Physical Therapy Assistant rendered the therapy under the direction of the licensed Physical Therapist. Therefore the insurance carrier's denial of "B20 – Srvc partially/fully furnished by another provider" is not supported.
3. Review of the submitted documentation finds that that the requestor is due reimbursement in accordance wwith 28 Texas Administrative Code §134.203 for CPT Codes 97113 and 97032 as follows:
   - Procedure code 97113, service date August 21, 2012, represents a professional service with reimbursement determined per §134.203(c), The Medicare fee is the sum of the geographically adjusted work, practice expenses and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.75 multiplied by the PE GPCI of 1.002 is 07.7515. The malpractice RVU of 0.01 multiplied by the Division conversion factor of $54.86 for a MAR of 66.09. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $66.09. The PE reduced rate is $57.84 at 6 units is $347.04. The total reimbursement for this code is $413.13.
   - Procedure code 97032, service date August 21, 2012, represents a professional service with reimbursement determined per §134.203(c), The Medicare fee is the sum of the geographically adjusted work, practice expenses and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.25 multiplied by the geographic practice cost indiex (GPCI) for work of 1.009 is 0.25225. The practice expenses (PE) RVU of 1.28 multiplied by the PE GPCI of 1.002 us 0.28056. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.54204 is multiplied by the Division conversion factor of $54.86 for a MAR of $29.74. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $26.66.

Total reimbursement for the disputed CPT Codes 97113 and 97032 is $439.79

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $439.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $439.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 10, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.